BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

SHAKEEL KAHN, M.D.,

Holder of License No. **37896**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-10A-37896-MDX

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Letter of Reprimand)

On August 11, 2010, this matter came before the Arizona Medical Board ("Board") for oral argument and consideration of the Administrative Law Judge (ALJ) Brian Brendan Tully's proposed Findings of Fact and Conclusions of Law and Recommended Order. Shakeel Kahn M.D., ("Respondent") appeared before the Board with legal counsel William Carroll. Assistant Attorney General Anne Froedge, represented the State. Chris Munns, Assistant Attorney General with the Solicitor General's Section of the Attorney General's Office, was present and available to provide independent legal advice to the Board.

The Board, having considered the ALJ's decision and the entire record in this matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. The Arizona Medical Board ("Board") is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.
2. Shakeel A. Kahn, M.D. ("Respondent") is the holder of License No. 37896 for the practice of allopathic medicine in the State of Arizona.
3. By letter dated June 26, 2009, Gerald C. West, M.D., the Chief of Staff at Valley View Medical Center in Fort Mohave, Arizona, informed Respondent of the following:

> This is to inform you of a summary suspension starting today at 17:00 June 21, 2009 of all of your physician member staff privileges. This is due to willful disregard of Medical Staff Rules and

> Regulations requirement of daily patient visits, during the month of June.
>
> Per medical Staff Bylaws you are required to be present on June 29th at 17:00 in the Board Room to explain your conduct concerning the medical records: [LM, GJ, and TP].

4. By letter dated August 11, 2009, Dr. West advised the Board of the following events involving Respondent:

> The purpose of this letter is to inform you that the above referenced physician was summarily suspended from the medical staff of Valley View Medical Center on June 26, 2009 for failure to see his hospital patients on a daily basis, in violation of hospital policy. His privileges were reinstated on June 29, 2009. The MEC[1] took these actions solely in the interest of quality healthcare and to assure patient safety. Further, Dr. Khan's [*sic*] actions may have constituted unprofessional conduct pursuant to ARS 32-1401 (25)(q).

5. After receiving Dr. West's letter, the Board initiated case number MD-09-1041A to investigate the allegations against Respondent.

6. By letter dated August 18, 2009, Marlene Young, the Board's Case Manager, informed Respondent that the Board had opened an investigation regarding the suspension of his hospital privileges and the alleged patient abandonment. Respondent was requested to submit a written response to the allegations no later than September 2, 2009.

7. By letter dated September 1, 2009, to Ms. Young, Respondent filed his response to her August 18, 2009 letter.

8. By letter dated November 6, 2009, Ms. Young informed Respondent that the Board had decided to review the patient records for the following patients: LM, TP, and GJ. Respondent was requested to "provide a written narrative response specifically to the care and treatment you provided to the above-mentioned

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[1] Medical Executive Committee.

patients and to the allegation of patient abandonment." Respondent's response was due no later than November 20, 2009.

9. By letter dated November 17, 2009, Respondent replied to Ms. Young's November 6, 2009 letter.

10. Kathleen M. Coffer, M.D. was assigned to Case No. MD-09-1041A as the Board's Medical Consultant. Dr. Coffer is board certified in Internal Medicine. She worked and taught at the Veteran's Administration hospital for approximately 13 years.

11. On December 23, 2009, Dr. Coffer prepared a Medical Consultant Report in Case No. MD-09-1041A.

12. In her Medical Consultant Report, Dr. Coffer opined that Respondent met the standard of care in his treatment of patients GJ and TP, who had been admitted to the Acute Rehabilitation Unit of Valley View Medical Center.

13. Respondent was patient LM's primary care physician.

14. On June 6, 2009, LM was admitted to the Emergency Department of Valley View Medical Center after falling at her home. At the time of her admission, LM was 57 years old. During her hospitalization which lasted weeks, LM was transferred to the hospital's Med/Surg floor and later to the hospital's ICU.

15. Respondent was LM's attending physician during her hospitalization at Valley View Medical Center.

16. In her Medical Consultant Report, Dr. Coffer further opined that the following proposed standard of care was applicable to Respondent's treatment of patient LM as her attending physician:

> It is the standard of care for the attending physician to see a patient hospitalized on the Med/Surg floor of the hospital on a daily basis and to document a daily progress note which addresses active medical problems and lab abnormalities. If an attending provider will be unavailable, it is the standard of care for the attending physician to arrange appropriate coverage to follow the patient on a daily basis. The plan for cross-coverage should be clearly documented along with the name and contact information for the covering provider. It is additionally the standard of care for the attending physician to be aware of a patient's increased O2 requirements and to attempt to determine the etiology by re-interviewing the patient about pulmonary symptoms, closely examining the patient, and

> ordering timely chest imaging studies and sputum cultures for further assessment. It is also the responsibility of the attending physician to be aware of Chest X-ray results. When the attending physician is contacted regarding continued hypoxia on supplemental Oxygen, it is the standard of care for the physician to go to the hospital and evaluate the patient. When the physician is subsequently contacted that the patient is ashen with a rapid respiratory rate, and has pneumonia reported on a previously obtained chest X-ray, the attending physician should immediately go in and evaluate the patient. It is also appropriate to order an urgent Pulmonary consultation.

17. Dr. Coffer's Medical Consultant Report contains her following analysis regarding Respondent's deviation from the standard of care in his treatment of LM:

> Dr. Kahn deviated from the standard of care by not seeing LM and documenting progress notes on June 12th, June 13th, June 14th, June 15th, June 16th and June 21st, 2009. Dr. Kahn also deviated from the standard of care by failing to further explore the patient's increased oxygen requirements from June 12th through June 19th. Dr. Kahn also deviated from the standard of care by failing to follow up on Chest X-rays that were obtained on June 20th, and June 21st that showed bilateral infiltrates. Dr. Kahn additionally deviated from the standard of care when he failed to come in and personally assess a hospitalized patient who remained hypoxic on supplemental Oxygen. He also deviated from the standard of care when he failed to come in urgently and evaluate the patient when she was on 50% venti-mask and had findings of acute respiratory failure.

18. In her Medical Consultant Report, Dr. Coffer also identified the following actual harm to patient LM, the potential harm to the patient, and aggravating factors resulting from Respondent's treatment of patient LM:

> **Actual Harm Identified:**
>
> LM developed severe pneumonia with acute respiratory failure while hospitalized and required ICU transfer and urgent Pulmonary consultation.
>
> **Potential Harm Identified:**

LM's sedation from IV Dilaudid and anxiolytic medication may have contributed to her respiratory depression.

Aggravating Factors:

It is aggravating that Dr. Kahn restarted Ativan and increased the Dilaudid dose after the pulmonary consultant had stopped the Ativan and reduced the Dilaudid dose when LM was lethargic and sleepy.

19. By letter dated December 30, 2009, Ms. Young sent Respondent a compact disc containing Dr. Coffer's Medical Consultant Report and the supporting documents. Respondent was requested to file a response to the Medical Consultant Report on or before January 14, 2010.

20. By letter dated January 19, 2010, Respondent filed his response to Ms. Young's December 30, 2009, letter.

21. Respondent's response to the Medical Consultant Report contained the following criticism:

> I begin my response to the consultant by reminding the Arizona Medical Board that the allegation made was one of abandonment of care, which term has a strict legal definition, and not whether there was a deviation from the proposed standard of care.
>
> The first problem that is apparent on the face of the consultant's report is her conclusion as to what constitutes the standard of care. Rather than the standard being uniform she opines that it is nothing more than the bylaws of the hospital or even policy statements within the hospital. This opinion creates differing standards of care within one hospital. In any event it will be obvious that the hospital was best equipped to interpret its own by-laws and make decisions regarding conformity with those "standards". [*sic*] Valley View Medical Center's Medical Executive Committee, which consisted of the Chief of Staff (Gerald West, M.D.), the Chief of Surgery (Richard Cardone, M.D.), the Chief of Medicine (Ances Arshad, M.D.), the Chief of Anesthesia (Paul Sutera[,] M.D.), the Chief Nursing Officer (Douglas Coffey, R.N.), and the Chief Executive Officer (Allen Peters) all unanimously opined that my actions did not pose a threat to the lives of my patients thereby implying that there was no harm done and the standard of care was maintained overall.

22. Respondent's response to the Medical Consultant Report contained the following statement as to Respondent's treatment of patient LM:

> LM is a 57 year old female who has chronic back, hip and leg pain and uses Percocet 10/325 tablets six times daily to control pain. She has done so for the last two years. LM had been improving from the date of her admission to approximately June 20. On that day it is noted that her O2 demand had increased but she also was not complaining of dyspnea. In fact nursing notes only identify that she had fine crackles in the base of her lungs. Lasix was appropriately ordered for her. Nursing notes do not, as the consultant states, show that LM was deteriorating.
>
> Other than Dr. Arshad, who is a Pulmonologist and Chief of Medicine, stating in his dictation that LM had been hypoxic for 24 hours no objective nursing data exists to support this fact. He of course was not aware of her entire medical history. He noted that she was in mild respiratory distress, not respiratory failure as the consultant states.
>
> Respiratory failure is a syndrome in which the respiratory system fails in one or both of its gas exchange functions; oxygenation and carbon dioxide elimination. In practice, respiratory failure is defined as PaO2 value of less than 60 mm Hg while breathing air or a PaCO2 of more than 50 mm Hg. Furthermore, respiratory failure may be acute or chronic. No ABG data is noted to show that LM was in respiratory failure. Her requirement for more O2 was also caused by her non-compliance with keeping her mask on as noted in nursing notes.
>
> The consultant also states that by starting Ativan for agitation and giving a single dose of 1 mg of IV Dilaudid when LM was complaining of 10/10 pain resulting in reduction of her pain to 5/10 that I aggravated her respiratory depression. No objective evidence is found in any nursing note to support such an allegation. In fact nursing notes support the fact that when patient LM was in pain, the IV Dilaudid curbed her pain and let her rest comfortably. Furthermore, LM was not a naive narcotics patient having been on strong doses of Percocet for many years.
>
> Giving Ativan to a patient who has a strong anxiety component to her shortness of breath and is a recovering alcoholic is an acceptable strategy and one that I was taught to use to prevent [*sic*] has provided a voluntary statement categorically denying that she ever

felt abandoned or was not aware of my absence for no more than five days due to a family emergency.

At the end of the day the overall care that LM received was above and beyond the ordinary standard of care expected of physician. No physician can be held to account for every action or inaction taken in the course of care of a patient. Errors were made but corrected for. [*sic*]

23. By memo dated January 20, 2010, Dr. Coffer wrote the following response to Respondent's response to her Medical Consultant Report:

> I have reviewed the statutory response sent to the Arizona Medical Board by Dr. Kahn. In his response, Dr. Kahn reported that other than the Pulmonologist stating in his dictation that LM had been hypoxic for 24 hours there was no objective nursing data supporting this fact. As stated in the IMC report, nursing notes of June 21st, 2009 documented an O2 saturation of 81% at 14:40PM. At 17:00 PM, nursing notes documented an O2 saturation of 83%. Further documentation by nursing reported that Dr. Kahn was notified regarding decreased O2 saturations, and a venti-mask was placed on LM with saturations of 89-91% if she kept it on. As reported, Dr. Kahn did not see LM or document a progress note on June 21st.
>
> Dr. Kahn also discusses the syndrome of respiratory failure and reports that there was no ABG data noted to show that LM was in respiratory failure. The prior IMC report includes excerpts from nursing notes on June 22nd, 2009 which noted a respiratory rate of 24 and described LM with a dusky color to her lips, an ashen face, and O2 saturations in the low 80s when she removed her O2 mask. The pulmonary consultant additionally listed acute respiratory failure as his first impression on his urgently performed consultation that morning. The pulmonary consultant also documented that details of the history were obtained from the record as the patient was in distress and appeared to be a little lethargic.
>
> Dr. Kahn additionally reported, "The consultant also states that by starting Ativan for agitation and giving a single dose of 1 mg of IV Dilaudid when LM was complaining of 10/10 pain resulting in reduction of her pain to 5/10 that I aggravated her respiratory depression." The IMC report actually identified potential harm, noting that LM's sedation from IV Dilaudid and anxiolytic medication may have contributed to her respiratory depression. It was also felt to be aggravating that Dr. Kahn restarted Ativan and increased the Dilaudid dose after the pulmonary consultant had stopped the Ativan

and had reduced the Dilaudid dose when LM was lethargic and sleepy.

In his response, Dr. Kahn concludes, "No physician can be held to account for every action or inaction taken in the course of the care of a patient. Errors were made but corrected for."

After review of the Licensee Response, my opinion regarding the Standards of Care and the cited deviations remain unchanged.

24. The Board's Staff Investigational Review Committee ("SIRC") prepared a written Recommendation dated February 18, 2010 in Case No. MD-09-1041A. SIRC was comprised of Christi Banys, the Board's Operations Manager, William Wolf, M.D., the Board's Chief Medical Consultant, and Celina Shepard, the Board's Case Review Assistant Manager.

25. The SIRC Recommendation listed the following Standard of Care/Deviation:

Standard:

1. The standard of care requires an attending physician to see a patient hospitalized on the Med/Surg floor of the hospital on a daily basis and document a daily progress note which addresses active medical problems and lab abnormalities.
2. The standard of care requires an attending physician to be aware of a patient's increased oxygen requirements and to attempt to determine the etiology by re-interviewing the patient about pulmonary symptoms, closely examining the patient, and ordering timely chest imaging studies and sputum cultures for further assessment.
3. The standard of care requires an attending physician to be aware of chest x-ray results.
4. The standard of care when the attending physician is contacted regarding continued hypoxia on supplemental oxygen, requires the attending to go to the hospital and evaluate the patient.
5. The standard of care when the attending physician is subsequently contacted that the patient is ashen with a rapid respiratory rate, and has pneumonia reported on a previously obtained chest x-ray, requires the attending physician to immediately go in and evaluate the patient.

Deviation:

1. Dr. Kahn deviated from the standard of care by failing to see LM and document progress notes on June 12-16, and 21, 2009.
2. Dr. Kahn deviated from the standard of care by failing to further explore LM's increased oxygen requirements from June 12-19, 2009.
3. Dr. Kahn deviated from the standard of care by failing to follow up on chest x-rays that were obtained on June 20 and 21, 2009 that showed bilateral infiltrates.
4. Dr. Kahn deviated from the standard of care by failing to come in and personally assess a hospitalized patient who remained hypoxic on supplemental oxygen.
5. Dr. Kahn deviated from the standard of care by failing to come in urgently and evaluate LM when she was on a 50% venti-mask and had findings of acute respiratory failure.

26. The SIRC Recommendation listed the following actual and potential harm to LM:

Actual Harm:

LM developed severe pneumonia with acute respiratory failure while hospitalized and required ICU transfer and urgent pulmonary consultation.

Potential Harm:

LM's sedation from IV Dilaudid and anxiolytic medication may have contributed to her respiratory depression.

27. The SIRC Recommendation found the following aggravating factor in Dr. Kahn's treatment of LM: "Dr. Kahn restarted Ativan and increased the Dilaudid dose after the pulmonary consultant had discontinued the Ativan and reduced the Dilaudid dose when LM was lethargic and sleepy."

28. The SIRC Recommendation contained the following SIRC Discussion:

SIRC noted that the MC identified several deviations from the standard of care in one of the three patients' records. SIRC stated that although Dr. Kahn has no prior Board history, he had numerous opportunities to present to the hospital to personally assess the patient. SIRC found that this matter rises to the level of discipline and recommended a Letter of Reprimand.

29. On March 25, 2010, the Board issued a Complaint and Notice of Hearing, which was designated Docket No. 10A-37896, charging Respondent with unprofessional conduct in his treatment of LM as her attending physician.

30. At hearing, Dr. Coffer testified consistently with her Medical Consultant's Report.

31. Patient LM testified on behalf of Respondent. LM stated that Respondent took good care of her, but that she felt someone should have come to see her in the hospital during the time Respondent left the country for several days to take his mother home to Canada for medical treatment. LM testified that she was only seen once by Dr. West.

32. Respondent is found to have deviated from the standards of care during his treatment of LM as described in the above Findings of Fact and as stated in the SIRC Recommendation.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent and the subject matter in this case.

2. Pursuant to A.R.S. § 41-1092.07(G) (2) and A.A.C. R2-19-119(B), the Board has the burden of proof in this matter. The standard of proof is preponderance of the evidence. A.A.C. R2-19-119(A).

3. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Respondent pursuant to A.R.S. § 32-1401(27) (q), which reads as follows: "Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public."

ORDER

Respondent's License No. 37896 shall be issued a Letter of Reprimand by the Board on the effective date of the Order entered in Docket No. 10A-37896-MDX/Case No. MD-09-1041A.

In addition to the above-provided Letter of Reprimand, Respondent is assessed the costs of formal hearing, pursuant to A.R.S. § 32-1451(M). Respondent shall pay the assessed costs of formal hearing within 60 days of billing from the Board, unless the Board or its designee grants an extension of time for payment.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 11TH day of August, 2010.

ARIZONA MEDICAL BOARD DITAT DEUS 1913 STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

By _____
LISA WYNN
Executive Director

ORIGINAL of the foregoing filed this 11th day of August, 2010 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

COPY OF THE FOREGOING FILED this 11th day of August, 2010 with:

Cliff J. Vanell, Director
Office of Administrative Hearings
1400 W. Washington, Ste 101
Phoenix, AZ 85007

Executed copy of the foregoing
mailed by U.S. Mail this
11th day of August, 2010 to:

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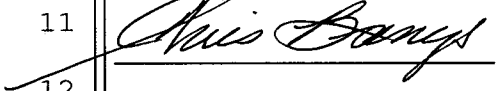

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